SUPPLEMENTAL INSTRUCTIONS

FOR COMPLETING THE

MEDICAL ELIGIBILITY DETERMINATION TOOL
For Section 96 - PDN – 'Venipuncture Only' or Psychiatric Medication Services

(MED)

BUREAU OF ELDER & ADULT SERVICES

February 1, 2000

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INTRODUCTION: MED REQUIREMENTS FOR PDN - VENIPUNCTURE ONLY AND PSYCHIATRIC MEDICATION SERVICES

Section 96 of the Maine Medical Assistance Manual for Private Duty Nursing and Personal Care Services has been expanded to allow for coverage of 'venipuncture only' and psychiatric medication services. Completion of certain pages of the MED tool is required for prior authorization and medical eligibility determination to access these services under this program. The completed outcome page must be submitted to classification review at BMS for data entry into Welfre and successful payments of claims.

Section 96.02- 4D Medication and Venipuncture Services for Severely Mentally Disabled Persons.

Section 96.02-4D allows for medication administration or monitoring services for a person who qualifies for the Community Support Services, Section 17, for Persons with Severe and Disabling Mental Illness. The recipient's eligibility shall be established by a completed "verification of eligibility form" described in Section 17, or otherwise by a signed certification by a physician that the recipient is eligible/covered under Section 17. Dated copies of this form/certification must be maintained in the recipient's record to verify eligibility for covered services. AND

A physician must sign and certify a statement that the recipient's medical condition prevents the safe use of outpatient services and is contraindicated (defined in 96.01-18) for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rarely. Reasons may include lack of services within a twenty (20) mile radius of the recipient's residence. Medicaid covers transportation to all Medicaid covered services, therefore lack of transportation does not qualify as an exemption.

The Provider Agency may determine medical eligibility for this level of services. In order to determine eligibility the following sections of the Med form must be completed.

The following sections of the MED tool must be filled out for Medication Services:
BACKGROUND INFORMATION (page 1 of 1):
SECTION HEADER (needs to be filled out on each page)
SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION
All of page 1 must be completed. Be sure to complete the homebound status in Box 20.

CLINICAL DETAIL (page 3 of 5) MEDICATIONS & DIAGNOSIS:
Section F. MEDICATIONS LIST: expectation that a medication prescribed for the treatment of severe and disabling mental illness will be present
Section G. MEDICATION: Additional codes for these 2 programs have been added under 1a. Preparation and Adminstration and 1b. Compliance.
1a. Preparation and Adminstration: # 6 - person requires administration of medications due to severe and disabling mental illness - would be entered into the box and/or

1b. Compliance : #4 - person requires monitoring of medications due to severe and disabling mental illness - would be entered into the box.
Section H. DIAGNOSES: expectation to see a Severe and Disabling Mental Illness diagnosis listed under Psychiatric/mood or listed in the other current diagnoses.

ELIGIBILITY DETERMINATION (page 2 of 4):
Section R10: MEDICATION SERVICES FOR PERSONS WITH SEVERE & DISABLING MENTAL ILLNESS: Complete the box by answering the questions and scoring appropriately.

COMMUNITY OPTIONS - CARE PLAN SUMMARY (page 1 of 1):
MEDICARE/3RD PARTY PAYORS: Box 6: Medicaire/3rd party payors: recipients with a Community Medicaid card may receive these services if determined medically eligible.

OUTCOME (page 1 of 1):
Section T: ASSESSMENT TYPE/VERSION: Complete the boxes according to the MED form instructions. For program eligibility "T-3" select #27
Section Z: COMMUNITY ELIGIBILITY: Program funding source is Community Medicaid, Provider is the HH agency name, eligibility start date is date of assessment, reassess date is the end of the current medical eligibility time period.
SIGNATURE: Complete assessment date, assessment version, sign name of person who determined medical eligibility and date signed.

Section 96.02- 4E Venipuncture Only Services

An individual meets the medical eligibility requirements for services under this section if the following are met:
The individual requires only venipuncture services on a regular basis, as ordered by a physician.
AND
A physician must sign and certify a statement that the recipient's medical condition prevents the safe use of outpatient services and is contraindicated (defined in 96.01-18) for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rarely. Reasons may include lack of services within a twenty (20) mile radius of the recipient's residence. Medicaid covers transportation to all Medicaid covered services; therefore lack of transportation does not qualify as an exemption.

The following sections of the MED tool must be filled out for Venipuncture Services:
BACKGROUND INFORMATION (page 1 of 1):
SECTION HEADER (needs to be filled out on each page)
SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION
All of page 1 must be completed. Be sure to complete the homebound status in Box 20

CLINICAL DETAIL (page 1 of 5):
Section B. Professional Nursing/Special Treatments and Therapies
1.e - Venipuncture by RN- Code here when service provided by either RN or LPN.

CLINICAL DETAIL (page 3 of 5) MEDICATIONS & DIAGNOSIS:
Section F. MEDICATIONS LIST: If venipuncture is needed to monitor blood levels for a specific medication, this medication section must be completed to document the medication being monitored by venipuncture.

ELIGIBILITY DETERMINATION (page 2 of 4):
Section R12: VENIPUNCTURE ONLY SERVICES: Complete the box by answering the questions and scoring appropriately.

COMMUNITY OPTIONS_- CAREPLAN SUMMARY (page 1 of 1):
Box 6: Medicaire/3rd party payors: recipients with a Community Medicaid card may receive these services if determined medically eligible.

OUTCOME (page 1 of 1):
Section T: ASSESSMENT TYPE/VERSION: Complete the boxes according to the MED form instructions. For program eligibility "T-3" select #28
Section Z: COMMUNITY ELIGIBILITY: Program funding source is Community Medicaid, Provider is the HH agency name, eligibility start date is date of assessment, reassess date is the end of the current medical eligibility time period.
SIGNATURE: Complete assessment date, assessment version, sign name of person who determined medical eligibility and date signed.

MEDICAL ELIGIBILITY DETERMINATION INSTRUCTIONS

BACKGROUND INFORMATION (page 1 of 1)

This section contains the applicant's demographic information as well as pertinent information to assist the assessor in reviewing programs for which the person may be eligible. This section may follow the person to prevent repetitive questioning and verification of demographic information by every provider. Appropriate release of information authorization for this section must be available to be shared with other providers. THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.** Providers may choose to type in their provider number and agency name and reproduce their own supply of forms.

SECTION HEADER

Medical Eligibility Header includes the following items: **Assessment Start Date**, **Name/Title of person coordinating assessment**, **Agency/Organization**, **Provider and Assessor number.**

ASSESSMENT START DATE: This date establishes a common reference point to reflect the applicant's status and expected care needs. For the month and day of the assessment, enter two digits each, using zero (0) in the first box for a 1-digit month or day; use four digits for the year.

NAME/TITLE OF PERSON COORDINATING ASSESSMENT: This should be the name of the person responsible for the completion of the assessment form. To the right of the name, enter this person's title.

AGENCY/ORGANIZATION: Enter the name of the agency or organization that is performing this assessment. To the right of the name, enter the phone number of the agency and extension of the coordinator, if applicable.

PROVIDER - ASSESSOR #: If applicable, enter the nine-digit Medicaid provider number of this agency/organization. This is the number assigned by Medicaid programs to your agency/organization for claims processing purpose. You can obtain this number from the Provider Relations Unit, Bureau of Medical Services. Each agency will need to assign individual assessor numbers to the nurses or social work staff assigned to complete assessments. Spaces for three digits have been provided. **Each person completing assessments for an agency should be assigned a unique assessor number. If and when the person leaves the agency, the number should be retired and never assigned to another assessor.** Data from the MED is collected by provider number and the Department will review data by the assessor number also.

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

A.1 Applicant Name: Print applicant's legal name clearly, using capital letters for first name, middle initial and last name.

A.2 Address: Give applicant's residential address and phone number at time of assessment. If person is in the hospital, give applicant's address prior to admission. If person is currently at a boarding or nursing home, give the name and address of that facility.

A.3- A.5 PLEASE ENTER THE FOLLOWING NUMBERS, STARTING IN THE LEFTMOST BOX. Enter one digit in each box. If there is no number, leave the boxes blank. Check the numbers to make sure you entered the digits correctly.

A.3 Social Security No.: Enter the applicant's Social Security number. This is a nine-digit number.

A.4 Medicaid No.: Enter the applicant's Medicaid number if applicable. This is a nine-digit number issued by the State.

A.5 Medicare No.: Enter the applicant's Medicare number, if applicable. Be sure to include any letters that follow the Medicare number.

A.6.a Assessment Trigger: Select the option that matches the referral request.

1. Service Need: Referent requests an assessment based on the consumer's need for service. May be used for any referral requesting a specific assessment for the programs listed in Section 6B. **For an initial medication or venipuncture services assessment, use "service need".**
2. Reassessment due: Only applies to people with currently complete and valid assessments due to expire. **For a reassessment for medication or venipuncture services, use Reassessment Due.**
3. Significant Medical Change: Only applies to people with a currently complete assessment. Indicators of significant change must be met (please refer to the definition of significant change).
4. Financial Change: Only applies to people with a currently complete assessment, for whom financial eligibility because of income, assets, or funding has changed.

A.6.b Program Assessment Requested: If assessing a consumer for Psychiatric Medication Services or Venipuncture Only Services under PDN, enter #1, Long Term Care Advisory.

A.7 Gender: Enter "1" for "Male" or "2" for "Female."

A.8 Race/Ethnicity: Consult the person as necessary. Enter the race or ethnic category within which the person places self. This is an optional question that can be left blank if the person prefers not to answer.

A.9 Birth date: Use all boxes. For a one-digit month or day, place a zero in the first box. For example, January 2, 1918, should be entered as 01-02-1918.

A.10.a Marital Status: Choose the answer that best describes the applicant's current marital status.

A.10.b. Citizenship: Choose one answer from "1" U. S. Citizen, "2" Legal alien, or "3" Other.

A.11 Primary Language: Code for the language that the person primarily speaks or understands. Enter "0" for English, "1" for French, "2" for Spanish, or "3" Other for any language other than English, French, or Spanish. If the primary language is none of the 3 listed languages, specify the language in the space provided.

A.12 Current Income Sources for Applicant and Household: Check all sources of income for the person and the household. In order to determine whether application to Medicaid as a potential funding source is feasible, and should be checked in **A.13**, the assessor will have to inquire about person and household asset amounts and other pertinent financial information. The assessor will need to know annual household income, amount of personal assets, and person's income to determine potential reimbursement sources. Household income is utilized when cost-sharing for some State funded programs is calculated. **The assessment will be considered incomplete if these boxes are not completed.**

A.13 Current or Potential Payment Source: Please code a response in each box for the current or potential payment sources for nursing facility level services needed. Identify the primary payer for the program the person is considering (e.g., elderly waiver, nursing facility, home-based care). Include all payment sources that are viewed as potential sources of reimbursement for the services necessary to meet the person's needs. Then, further determine if Medicare may also be a reimbursement source in the setting being considered. Refer to the appropriate programs for information on their financial eligibility requirements. For item j (other), code with a "0" if the payment source is not used. This includes private pay and refers to the client's income and assets as the first payor source, after Medicare, for nursing facility level services.

The choice in each box will reflect either a verified eligibility or an anticipated eligibility for the consumer. If the consumer has a valid Community Medicaid card then "1" for eligible should be recorded in 13a. Unknown should only be used if you are unable to get any financial information from the consumer or responsible party. Another example when "4" is the appropriate code may be when the information is so unclear that the assessor cannot make an educated determination as to what financial category might be appropriate. Be sure to offer outreach services to assist the consumer with completion of the financial application.

0. **Not eligible**-The person is not financially eligible for this program and eligibility is not anticipated at this time.
   For item **j (other)**, code with a "0" if the payment source is not used.

1. **Eligible** - The person is financially eligible for this program or insurance. Eligibility refers to the applicant's financial eligibility to be on the program.

   For item **j (other)**, code with a "1" if other payment source (such as 3rd party, long term care insurance, private pay) is used.

2. **Eligibility pending** - An application has been filed at the BFI regional office for this program or insurance. A determination has not been reached as of the assessment start date.

3. **Eligibility anticipated** - An application has not been filed, but based on initial financial information collected, eligibility is anticipated and the application will be filed.

4. **Unknown** - Financial eligibility is unknown for this payment source.
   [Note: This coding differs from the MDS coding.]

A.14 A. Location at Time of Assessment & B. Usual Place of Residence: Enter the corresponding number for the location of the person on the assessment date. Also enter corresponding number for Usual Place of Residence.

A.15 Usual Living Arrangement: Check all appropriate boxes for whom the person lives with at his/her current residence. If person is being assessed for nursing facility eligibility while at the hospital, check appropriate box for his/her residence prior to hospitalization.

A.16 Number in Household (incl. applicant): Enter the number of people who live in the applicant's household including the consumer. For those consumers who live in an institution or residential care facility, code **NA** in the boxes.

A.17 Responsibility/Legal Guardian: Before completing this item, be sure that you are familiar with the legal definitions. Refer to full MED instructions which include: A Primer on Powers of Attorney, Guardianship and Related Issues for Long Term Care Assessors by Sally M. Wagley, Esq., Maine Department of Human Services, Bureau of Elder and Adult Services (6/21/96) for additional information. Check all that apply.

A.17 Responsibility/Legal Guardian: Check only those items with available documentation which indicates that someone else is responsible for participating in legal decisions about the applicant's **health care and treatment.**

a. Legal Guardian: Guardians are appointed after a court hearing and are authorized to make decisions that include giving and withholding consent for medical treatment. Once

appointed, only another court hearing may revoke the decision-making authority of the guardian.

b. Other Legal Oversight: Any other program in the state whereby someone other than the person participates in or makes decisions about the applicant's health care and treatment, e.g., conservator, temporary guardian, or financial POA.

c. Durable Power of Attorney/Health Care Proxy: Documentation that someone other than the person is legally responsible for the applicant's legal affairs, or for health care decisions if the person becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the applicant's wishes for care. **[Note: Unlike a guardianship, the person can revoke durable power of attorney/health care proxy terms at any time.]**

d. Family Member: Includes immediate family or significant other(s) as designated by the person. Both the person and the family may share responsibility for decision-making.

e. Applicant: Applicant retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, assume that the person is the responsible party.

f. Other: If the individual has financial or other restrictions, with supporting documentation, not indicated elsewhere.

g. Unknown: Legal guardianship or responsibility for the applicant's **health care and treatment** is unknown.

A.18 Advanced Directives: Federal law requires that people be told about their right to make decisions about their health care choices. The medical record in the nursing facility or hospital setting includes the necessary information to determine what category to check. AAA's have available a comprehensive record of information on most of the people they serve. All health care providers are required to ask people about their preferences and should be knowledgeable and comfortable in discussing these basic issues as professional health care providers. If assessing in the community and no advanced directives are available, the options need to be explained to the person as mandated by Federal law, and information should be made available to him or her. The booklet prepared by BEAS, **Taking Charge of your Health Care** includes information to assist people in making a decision about a living will or advanced directive and also includes a card with pertinent information about these two documents for them to complete and carry in their wallets. Copies of this booklet are available from BEAS. Familiarize yourself with the legal status of each type of directive. Review medical records, when available, for written documentation verifying the existence and nature of these directives. Documentation must be available in the record for a directive to be considered current and binding. Check all items that apply and have supporting documentation available.

a. Living Will: A document specifying applicant's preferences regarding measures used to prolong life when there is a terminal prognosis. It may specify that no heroic measures are to be used to prolong life when there is a terminal prognosis.

b. Do not resuscitate orders: In the event of respiratory or cardiac failure, the person or family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore respiratory or circulatory function.

c. Do not hospitalize order: A document specifying that person is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

d. Organ donation: Instructions indicating that person wishes to make organs available for transplantation upon death.

e. Autopsy request: Document indicating that the person or family or legal guardian has requested that an autopsy be performed upon death. **[Note: The family must still be contacted prior to performing the procedure.]**

f. Feeding restrictions: Applicant or family or legal guardian does not wish the person to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

g. Medication restrictions: Applicant or family or legal guardian does not wish the person to receive life-sustaining medications (e.g., antibiotics, chemotherapy) **[Note: These restrictions may not be applicable, however, when these medications are used to ensure the applicant's comfort.]**

h. Other treatment restrictions: Applicant or family or legal guardian does not wish the person to receive certain medical treatments. Examples include, but are not restricted to, blood transfusion, tracheotomy, respiratory intubation, restraints. **[Note: These restrictions may not relate to care given for palliative reasons, such as reducing pain, or distressing physical symptoms, such as nausea or vomiting.]**

Check all directives that apply. If none are verified by documentation in the medical records, check **i. None of Above**.

A.19 Contacts: Enter names and addresses of people who can be contacted in the event of emergency involving the person. List their telephone numbers and relationship to the person. Also, check whether that person is a legal guardian.

A.20 Referring/Continuing Physicians: List names, addresses, and phone numbers of both the referring physician and the continuing physician.

Homebound Status: Enter 0 or 1 for homebound status: No/Yes. Homebound status equals "Yes" if the physician has certified that the consumer is homebound or meets the homebound exemption criteria found in Section 40 of the Medicaid Home Health rules.

CLINICAL DETAIL (page 1 of 5)

Clinical Detail Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #,** and **Assessment Date**. THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

SECTION B. PROFESSIONAL NURSING SERVICES/SPECIAL TREATMENTS AND THERAPIES

Code for the number of days care would be performed by or under the supervision of a registered professional nurse. Use the following codes.

0. Not required
1. 1-2 days/week
2. 3 or more days/week
3. Once a month

B.1 **Treatments/Chronic Conditions**- Professional nursing care and monitoring for the administration of procedures which involve prescription medications for post-operative or chronic conditions according to physician orders. Physician orders for procedures should be reflected on the order sheet. **The box must be coded with a response.**

e. Veni puncture by RN This is the drawing of blood from a person, to be sent to a lab for doctor ordered lab studies to monitor the person's condition or response to treatment. Policy allows venipuncture by a Licensed Practical Nurse. Use this box to indicate venipuncture being done by either a LPN or RN.

CLINICAL DETAIL (page 3 of 5) MEDICATIONS & DIAGNOSIS

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #**, and **Assessment Date**. THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

Section F. MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the person's treatment regimen.

For consumers being assessed for 'Venipuncture Only' services under PDN, any medication/s which need to be monitored through venipuncture should appear on this list.

For consumers being assessed for Psychiatric Medication Services under PDN, all medications being administered or monitored should appear on this list, as well as any medications taken within the last 7 days.

1. List the **medication name** and the **dosage**.
2. Route of Administration: list the appropriate code, 1 through 10.
3. Frequency: use the appropriate frequency code as listed.
4. PRN-n: If the frequency code is "PR," record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.
5. Drug Code: Enter the National Drug Code (NDC) if known. The last 2 digits of the 11-digit code define package size and have been omitted from the codes listed in the manual Appendix. If using this Appendix, place the first digit in the first space. The last two spaces will be blank.

Section G. MEDICATION

Intent: To record whether the person prepared and administered any of his/her own medications in the last 7 days.

1 a. Preparation/Administration: Enter 0, 1, 2, or 3, 4, 5 or 6 in the box provided.

Coding:

0. Person prepared and administered All of his/her medications
1. Person prepared and administered Some of his/her medications.
2. Person prepared None of his/her medications
3. Person had no medications in the last 7 days
4. Person did not prepare but did self administer all medications
5. Facility prepares and administers medications
6. Person requires administration of medications due to severe and disabling mental illness.

b. Medication Compliance

Intent: To determine if there are specific or potential problems with the person's medications or the way the person takes medications.

Process: Review the person's medication, question the consumer, family or caregivers to assess how well the person complies with the medication ordered by a physician/psychiatrist. If in a facility, check with direct care staff.

Coding: Enter in the box the appropriate number that represents the person's level of compliance during the last 30 days.

0. Person always compliant
1. Person compliant some of the time (80% of time or more often) or compliant with some medications
2. Person rarely or never compliant
3. Person had no medications in the last 7 days.
4. Person requires monitoring of medications due to severe and disabling mental illness.

c. Self Administration:

Intent: To record whether the person self-administered any of the following medications in the last 7 days: insulin, oxygen, Nebulizers, Nitropatch, glucoscan, or over-the counter medications. Please specify if there were any other self-administered medications.

Coding: Check all responses a, b, c, d, e, f, g, or h, that apply. If the person does not self-administer any medications, check NONE OF ABOVE.

Section H. DIAGNOSES

1. DIAGNOSES Check only those diagnoses that relate to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death. Do not list inactive diagnoses. **Check xx if NONE OF ABOVE.**

2. OTHER CURRENT DIAGNOSES AND ICD-9 CODES: Complete if appropriate.

ELIGIBILITY DETERMINATION (page 2 of 4)

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #**, and **Assessment Date**. THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

MEDICATION SERVICES FOR PERSONS WITH SEVERE AND DISABLING MENTAL ILLNESS

R.10.

a. Check 'Yes' if there is a physician certification in the person's record verifying the person's eligibility or coverage for services under Section 17 of the Maine Medical Assistance Manual, for Severe and Disabling Mental Illness. If the person has not been certified under Section 17 but would be covered according to physician, then this can be checked 'Yes'.
b. Check 'Yes' if physician has certified that use of outpatient services is contraindicated for this person.

If the answer to both of these questions is 'Yes', then enter a '1' in the box.

R.11.

a. Check 'Yes' if Section G1a, Medication Preparation/Administration, is coded with a '6'.
b. Check 'Yes' if Section G1b, Medication Compliance, is coded with a '4'.

If the answer to either of these questions is 'Yes', then enter a '1' in the box.
If both R.10 and R.11 are scored with a '1' then person appears eligible for Medication Services under the PDN program. Otherwise, the person appears **NOT** to be medically eligible for Medication Services.

VENIPUNCTURE ONLY SERVICES

R.12.

a. Check 'Yes' if there is a physician order in the person's record for ONLY venipuncture services on a regular basis.
b. Check 'Yes' if physician has certified that use of outpatient services is contraindicated for this person.
c. Check 'Yes' if Section B1e, Venipuncture, is coded with a 1, 2, or 3.

If the answers to R.12 a., b., and c. are 'Yes' then enter a '1' in the box. Person appears eligible for Venipuncture Only Services under the PDN program. Otherwise, the person appears NOT to be medically eligible for Venipuncture Only Services.

Paste coding sheet here. Circle the new and current codes that apply to these programs.

Refer to the coding sheet on the previous page when filling out the care plan summary.

COMMUNITY OPTIONS - CARE PLAN SUMMARY (page 1 of 1)

Header Complete the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, Social Security. Refer to the coding sheet on previous page when completing this care plan summary.**

SECTION S. 6. MEDICARE/3RD PARTY PAYORS:

Indicate Medicare/ Community Medicaid services in this block. For the **Medicare/Third Party Payor** Block, use the following code: **code 23 for Community Medicaid**.

1. Funding Source: Enter the payment code 23, for Community Medicaid, which will pay for the recommended medication or venipuncture service.

2. Service Category: Enter the appropriate code to indicate the service category recommended to meet the need. Be sure that the service category selected is reimbursable under the program/funding source.

For Medication Services, the service category is #42 – Psychiatric Medication Services. You may also select service category #9 or 11, depending on whether the person needs venipuncture and whether it is a RN or LPN, by the hourly rate.

For Venipuncture Only Services, the service category is either #9 or 11, depending on whether it is a RN or LPN by the hourly rate.

3. Reason Code/Need met: List the reasons for service. New reason codes have been added for these programs.

For Medication Services, the reason code is #30 – Monitor, administer, and/or prefill of psychiatric medications. Also select #31 - Venipuncture if the person requires venipuncture for medication monitoring.

For Venipuncture Only Services, the reason code is #31 – Venipuncture.

4. Duration Enter the **4a. Start Date** and **4b. End Date** for the proposed service**.**

5. Unit Code Enter the unit of time which is used in calculating the cost of this service. In this case, use code "2 = ½ hour", the unit code per Chapter III of Section 96 for reimbursement.

6. Number of units per month Enter the number of units needed *per month* to meet the person's needs.

7. Rate per unit: Enter the current rate for this service based on the maximum allowable Medicaid rate for that specific unit of service in this program as found in the appropriate Medicaid manual.

8. TOTAL cost per month. To calculate the total monthly cost for each service for Column "8", take the number of units per month in Column 6 and multiply by the rate per unit in Column 7.

OUTCOME (page 1 of 1)

Outcome Header Complete the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, and Social Security number.**

This section of the MED form communicates information about the medical eligibility outcome of the assessment and crucial dates that may start or end payment for services. It also tracks the reassessment due dates and appeal status when applicable. **This is the page that must be sent to BMS for classification entry into the Welfre system to assure payment of claims.**

Section T:

1. Type. Indicate whether this is an initial or reassessment. The **initial assessment (1):** is the first assessment completed on a consumer triggered by a specific request. The **reassessment (2):** A consumer has an existing valid assessment due to expire and requires reassessment for determination of continued medical eligibility. A reassessment may also apply when a consumer chooses to transfer from one specific program or funding source to another program or funding source. A significant change in the consumer's condition, improvement or deterioration, may also trigger a reassessment. Reassessment replaces the term reclassification across all program and funding sources.

2. Version: Any change to the original version of an assessment is labeled as a version. Changes may occur to the original version of the assessment, according to policy and procedural parameters. These may be triggered by a change in financial circumstances, a change in a consumer's choice of program or provider, a change in the status of the assessment based on due process and/or allowable revisions in the eligibility start and end dates when justified by certain circumstances. Any change to the "original" version is labeled a specific version as defined below.

Original (1): The original version of an assessment. Each assessment regardless of whether it is an initial or reassessment has an "original" version, the version completed at the time of the face to face assessment.

Revision (2): A change in the eligibility begin and end dates, or program begin and end dates or programs denied dates, or provider chosen, or data error may require a "revision" to the original assessment. The changes required are reflected in the "revision" version of the original assessment.

3. Assessment requested*:* Column 1 records the assessment requested at the time of the referral and should match the request from Section A-6b background information. For these programs, the assessment requested is #1 – Long Term Care Advisory.

Program Eligibility: Column 2 records the program eligibility calculated, based on the clinical detail portion of the assessment.

Check #27 for PDN Psychiatric Medication Services.

Check #28 for PDN Venipuncture Only Services

Section Z. Community Eligibility

This table includes only program /funding sources that are **authorized,** by the assessor, based on the medical eligibility determination. Fill in:

Program/ Funding source: This must agree with the medical eligibility determination and the consumer's choice and the careplan summary. The program/funding source for these programs is #23 – Community Medicaid. Remember that there may be more than one service category listed on the care plan summary page. This table deals with program funding sources rather than services categories.

Provider: Fill in the provider name for the agency responsible for implementing the plan of care under the program funding source selected. Example: PDN for Venipuncture, the provider is the Home Health Agency delivering this service.

Eligibility Start date: This date indicates the date that the services authorized may begin and have been approved for by the medical eligibility determination outcome. **In cases where services started between January 1, 2000 and February 28, 2000, due to the service no longer being covered under Section 40, Medicaid Home Health, the Eligibility date = date service started. Example: Assessment done February 28, 2000. Service started February 1, 2000. Eligibility date = February 1, 2000.**

Reassess date: This date is the date that the medical eligibility ends and the assessment outcome becomes invalid. Essentially the medical eligibility determination to access services expires. For care to continue and the provider receive reimbursement for services delivered, an assessment is required to determine continuing medical eligibility**. PAYMENT ends with the reassessment date.**

Signature:

Enter the Assessment date, enter the version of this assessment, sign the form, and enter the date of your signature.

APPENDIX

1. Psychiatric Medication Services

2. 'Venipuncture Only' Services